

REQUIREMENTS AND INSTRUCTIONS FOR FILING - PHARMACY

Access this form via website at: www.state.hi.us/dcca/pvl

APPLICATION FORM

Type or print *legibly* in dark ink.

SELF-INSPECTION REPORT

Complete Pharmacy Self-Inspection Report and attach a diagram of the floor plan of the premises showing the specific location of the prescription area. Diagram the space and location of fixtures such as counters, tables, drawers, shelves, storage cabinets including a locked cabinet, library, sink with hot and cold water, proper sewage outlet, and refrigeration storage equipment. Identify the spaces and equipment. Attach photographs with captions to depict the above.

NEW LICENSE-BUSINESS FORMERLY OWNED BY SOMEONE ELSE

ATTACH a letter of verification from the former owner that the pharmacy has been bought with the effective date of sale.

CORPORATION/ PARTNERSHIP/LLC/LLP

If the applicant is a corporation, partnership, LLC, or LLP, submit the following proof to show that the entity is properly registered with the Business Registration Division (BREG), Department of Commerce and Consumer Affairs, State of Hawaii (phone (808) 586-2727) or visit their website at: www.businessregistrations.com/home.html to order Certificates of Good Standing, forms, etc.

If the corporation/partnership/LLC/LLP has been registered in this state for LESS THAN ONE (1) YEAR, ATTACH a "*filed-stamped*" copy of the document filed with BREG; or the same certificate mentioned below.

If the corporation/partnership/LLC/LLP has been registered in this state for MORE THAN ONE (1) year, ATTACH a current "*Certificate of Good Standing*" or "*Certificate of Qualification*" issued not more than 1 year ago.

TRADE NAME

If you are planning to use a trade name, attach proof of registration of the trade name approved by the Business Registration Division of the Department of Commerce and Consumer Affairs. (phone (808) 586-2727. (Not needed if your trade name is similar to your corporate name.)

FEES

Make check payable to *COMMERCE & CONSUMER AFFAIRS* for the applicable fees:

If applying for license in an EVEN-NUMBERED year, pay \$295
(Application fee-\$100, License-\$50, 1/2 renewal-\$75,
Compliance Resolution Fund-\$70).

If applying for license in an ODD-NUMBERED year, pay \$185*
(Application fee-\$100, License-\$50, Compliance Resolution Fund-\$35).

If applying for Relocation, pay \$100
(Application fee-\$100-license fee not required).

**ALL licenses expire on December 31, ODD-NUMBERED years and are subject to renewal regardless of license issuance date.*

Note: One of the numerous legal requirements that you must meet in order for your new license to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$15.00 service fee will be charged for checks which are returned by the bank.

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

(Continued)

ADDRESS OF BOARD

Mail all required items to: *Board of Pharmacy
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801*
or
Deliver to office location: *1010 Richards Street, 1st Floor
Honolulu, HI 96813
Phone: (808) 586-3000*

LAWS & RULES PUBLICATION

The license holder is held accountable for knowing and complying with the laws and rules relating to pharmacy practice as failure to comply may result in disciplinary action.

Copies of the laws and rules relating to pharmacies may be obtained by sending check or money order payable to COMMERCE & CONSUMER AFFAIRS, *Cashier, P. O. Box 541, Honolulu, HI 96809*. Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Law may be purchased separately for 75¢. **Price subject to change without notice.**

- Chapter 461, Hawaii Revised Statutes, Pharmacists & Pharmacies \$.50
- Title 16, Chapter 95, Hawaii Administrative Rules, Pharmacists & Pharmacies \$1.25
- Chapter 328, Hawaii Revised Statutes, Food, Drugs, & Cosmetics \$1.25
- Chapter 329, Hawaii Revised Statutes, Uniform Controlled Substances Act \$1.25

The rules are posted on our website at: www.state.hi.us/dcca/pvl, then click the specific board/program. The laws will be posted during the fall of 2001.

MATERIAL & EQUIPMENT REQUIREMENTS

Each pharmacy shall at all times possess the following minimum professional and technical equipment.

REFERENCE LIBRARY

- [] Federal Drug Enforcement Agency Regulations
- [] The Uniform Controlled Substances Law, HRS, Chapter 329
- [] State Food & Drug Laws, HRS, Chapter 328
- [] State Pharmacy Law, HRS, Chapter 461
- [] Pharmacy Administrative Rules, HAR, Chapter 16-95
- [] Prescription files

TECHNICAL EQUIPMENT

Equipment for dispensing and compounding shall include:

- [] Class A prescription balance or a balance of greater sensitivity and appropriate weights
- [] Mortar and pestle - Glass or porcelain
- [] Refrigerator
- [] Bottles and vials - Various sizes
- [] Graduates or other similar measuring devices
- [] Prescription labels

ATTACHED TO THIS APPLICATION ARE:

- [] Proof of Business Registration
- [] Proof of trade name (if used) registration
- [] Proof of sale (to include date of sale), if pharmacy had a previous owner
- [] Floor plan which diagrams location of fixtures and equipment
- [] Pharmacy self-inspection report, signed
- [] Description of security system
- [] Photographs that document prescription area, including fixtures, sinks, equipment, and security system

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

APPLICATION FOR LICENSE - PHARMACY				FOR OFFICE USE ONLY	License No. PHY-	No. Issued Date	Lic Effective Date																		
Applicant (Name of corporation, partnership, LLC or LLP; if individual, First, Middle, Last):																									
Trade Name (if any)																									
Location (include suite no., city, state & zip code)																									
Mailing Address, if different from location:		Phone No.		Check the type of application being made: <input type="checkbox"/> NEW LICENSE. Business was NOT owned by anyone else before. <input type="checkbox"/> NEW LICENSE for business that was formerly owned by someone else. Name of former Pharmacy: _____ <input type="checkbox"/> RELOCATION. Same owner but in a different location. Former location: _____																					
Website Address:	E-Mail Address:	Fax No.																							
Name of full-time Pharmacist in charge of prescription area		License No.																							
Names of other registered pharmacist employees		License No.																							
				Circle type of business entity: SOLE OWNER CORPORATION PARTNERSHIP LIMITED LIABILITY PARTNERSHIP LIMITED LIABILITY COMPANY																					
Name of Manager of store in which prescription area is located		Phone No.																							
RESIDENCE ADDRESSES	Name	Social Security No.	Residence Address	Phone No.																					
	Sole Owner																								
	President, Manager or Partner																								
	Vice-President , Manager or Partner																								
	Secretary, Manager or Partner																								
	Treasurer, Manager or Partner																								
The following questions pertain to the applicant and any persons (pharmacists, officers, directors, managers, partners, etc.) responsible for the distribution of drugs: 1) In the past 20 years, have you ever been convicted of a crime related to the pharmacy profession?..... YES NO 2) Has any license ever been disciplined (including suspension, revocation or fine) in another jurisdiction, including by a Federal or State regulatory body? YES NO 3) Have you ever been in violation of any State or Federal drug, controlled substance, or poison law? YES NO																									
List and explain all "YES" answers on a separate sheet and attach copies of court documents or the board's documents relating to these matters.																									
Affidavit of Applicant: I solemnly swear that the answers and statements contained in this application and the documents attached are true and correct. I understand that misrepresentation is grounds for refusal or subsequent revocation of license (<i>Section 710-1017, Hawaii Revised Statutes</i>). Further, I agree that the pharmacy for which the permit is sought is or will be in full compliance with all state drug, narcotic and poison laws, and Chapters 461 and 95, Hawaii Revised Statutes, and Title 16, Chapter 95, Hawaii Administrative Rules.																									
_____ Date				_____ Signature of Applicant																					
				_____ Print Name																					
				_____ Title																					
This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.				<table style="width:100%; border: none;"> <tr> <td style="width: 33%;">App.....</td> <td style="width: 33%;">496.....</td> <td style="width: 33%;">\$100</td> <td style="width: 33%;">CRF.....</td> <td style="width: 33%;">C13.....</td> <td style="width: 33%;">\$35/70</td> </tr> <tr> <td>Lic.....</td> <td>499.....</td> <td>\$ 50</td> <td>Service Fee</td> <td>BCF</td> <td>\$15</td> </tr> <tr> <td>½ Ren</td> <td>490.....</td> <td>\$ 75</td> <td colspan="3"></td> </tr> </table>				App.....	496.....	\$100	CRF.....	C13.....	\$35/70	Lic.....	499.....	\$ 50	Service Fee	BCF	\$15	½ Ren	490.....	\$ 75			
App.....	496.....	\$100	CRF.....	C13.....	\$35/70																				
Lic.....	499.....	\$ 50	Service Fee	BCF	\$15																				
½ Ren	490.....	\$ 75																							

BOARD OF PHARMACY
Department of Commerce and Consumer Affairs
Professional and Vocational Licensing Division
1010 Richards St., P. O. Box 3469
Honolulu, HI 96801
Access this form via website at: www.state.hi.us/dcca/pvl

PHARMACY SELF-INSPECTION REPORT

Date of Inspection: _____ Store Name: _____
Pharmacy Name: _____ Store Address: _____
Pharmacy Address: _____ Store Manager: _____
Pharmacy Hours: _____ Phone No: _____

Pharmacy Permit Displayed? [] YES [] NO

R. Ph. In Charge: _____

License No.: _____

License Displayed? [] YES [] NO

Expiration Date: _____

R. Ph on Duty: _____

License No.: _____

License Displayed? [] YES [] NO

Expiration Date: _____

Pharmacy Intern: _____

Permit No.: _____

(Attach additional sheets as needed)

Attach Store Label

PRESCRIPTION AREA

REFERENCE LIBRARY

Federal DEA Regulations [] YES [] NO
State Uniform Controlled Substances Law, HRS, Chapter 329 [] YES [] NO
State Food & Drug Laws, HRS, Chapter 328 [] YES [] NO
State Pharmacy Law, HRS, Chapter 461 [] YES [] NO
State Pharmacy Rules, HAR, Chapter 16-95 [] YES [] NO
Prescription Files (5 years) [] YES [] NO

TECHNICAL EQUIPMENT

Graduates or other similar measuring device [] YES [] NO
Mortar & Pestal (glass or porcelain) [] YES [] NO
Bottles & Vials (assorted) [] YES [] NO
Prescription Labels [] YES [] NO
Rx Balance (Class A) or a balance of greater sensitivity and appropriate weights [] YES [] NO

PRESCRIPTION AREA (Cont.)

- | | | |
|---|---------|--------|
| 1. Is pharmacy area adequately secured? | [] YES | [] NO |
| 2. Description and photographs of security system is attached? | [] YES | [] NO |
| 3. Is there a locked cabinet <u>or</u> is a description of how controlled substances
are to be secured attached? | [] YES | [] NO |
| 4. Adequate counters, tables, drawers, shelves and storage cabinets? | [] YES | [] NO |
| 5. Hot and cold water sink? | [] YES | [] NO |
| 6. Proper sewage outlet? | [] YES | [] NO |
| 7. Refrigeration storage equipment? | [] YES | [] NO |

Comments on any of the above: _____

I understand the Board reserves the right to verify this statement by a subsequent inspection. I further understand that a pharmacy license number will not be assigned until all deficiencies have been corrected. I shall submit a written statement to the Board of Pharmacy to attest that any deficiency has been corrected.

Date

Signature of Responsible Pharmacist in Charge

Date

Signature of Store Manager

SECURITY OF PHARMACY PRESCRIPTION AREA

Hawaii Administrative Rules, section 16-95-80, Physical Presence of a Registered Pharmacist, requires the following:

- a) A pharmacist must be physically present during the hours of operation of a prescription area, and
- b) At any time a registered pharmacist is not in the prescription area, the entire stock of prescription drugs shall be secured from access to unauthorized persons and the means of access shall only be in the possession of the pharmacist.

I/we the undersigned, acknowledge and understand the foregoing provision.

Signature of applicant or
company representative

Signature of pharmacist-in-charge

Print name of person signing

Print name of pharmacist-in-charge

Title

Date

Name of Pharmacy

Address of Pharmacy

Date

COMPLETE BOTH SIDES AND ATTACH TO APPLICATION FORM

LICENSING BRANCH
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

To receive confirmation of your license, fill in your name and mailing address in the block below on the *"Notice of Licensure" form*.

NOTICE OF LICENSURE

Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

This is authorization to act as a **PHARMACY** until such time that a license is processed.

THIS AUTHORIZATION IS VALID ONLY WHEN SIGNED BY THE EXECUTIVE OFFICER
OF THE BOARD.

Fill Name & Complete Mailing Address in block below:

LICENSE NO. PHY -

EFFECTIVE DATE _____

EXPIRATION DATE 12/31/

Executive Officer

LICENSING BRANCH
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

To receive confirmation of your license, fill in your name and mailing address in the block below on the *"Notice of Licensure"* form.

NOTICE OF LICENSURE

Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

This is authorization to act as a **PHARMACY** until such time that a license is processed.

THIS AUTHORIZATION IS VALID ONLY WHEN SIGNED BY THE EXECUTIVE OFFICER
OF THE BOARD.

Fill Name & Complete Mailing Address in block below:

LICENSE NO. PHY -

EFFECTIVE DATE _____

EXPIRATION DATE 12/31/

Executive Officer